H.1. Contractor Financial Underwriting of Healthcare Costs

a. General Discussion

(1) The Managed Care Support (MCS) contractor will underwrite the cost of civilian health care services (also referred to as "purchased care" which is defined as care rendered outside the Direct Care System) provided to all CHAMPUS-eligible beneficiaries* residing in the contract area except:

-- outpatient retail and mail order pharmacy services (on separate contracts)
-- Active Duty/Supplemental including TRICARE Prime Remote for service members (SM) only (family members (FMs) are underwritten by the MCS contractor)
-- Continued Health Care Benefits Program (CHCBP)
-- Foreign/OCONUS Claims (all)
-- Medicare dual-eligible TRICARE beneficiaries (separate contract)
-- Cancer/Clinical Trials

*CHAMPUS-eligible beneficiaries are defined as those beneficiaries that meet the requirements in Title 10, United States Code, Chapter 55.

(2) The underwriting mechanism will consist of an underwriting fee which may be considered to be an underwriting premium associated with the risk assumed by the contractor. It will be subject to a fee-adjustment formula or "fee curve," which allows for increases or decreases inversely related to the actual costs. There is potential for the contractor to earn a negative fee if the actual healthcare costs for a given contract year were significantly higher than a specified target cost for that year. The adjustment mechanism is described in the subsequent paragraphs.

b. Administration of Financial Underwriting by Contractor

(1) This paragraph defines and explains the mechanics and the administration process of the following:

-- target healthcare cost
-- target underwriting fee
-- minimum and maximum fee
-- formula to determine the underwriting fee within the minimum and maximum based on the relationship of actual costs to target costs (a "fee curve")
-- actual healthcare costs

Each of these parameters is explained below.

(2) Target health care cost. The target health care cost for each period of health care delivery will be set as follows:

(a) The target cost for health care delivery in option period I under the contract is set forth in Section B. This target cost includes the purchased-care costs for non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries residing in the area, whether they are enrolled with an MTF PCM, a network PCM, or are non-enrolled. The target cost will not change except for definitized healthcare changes or other equitable adjustment.

(b) For option period II and subsequent periods, the Government and the contractor will negotiate the target cost before the start of each option period and incorporate them in Section B of the contract. The negotiation process shall begin with the submission of a proposal by the contractor not later than the first day of the seventh month of option period one through four. Once the target cost for the next year is established, the only adjustments that would be made for that year would be for negotiated healthcare changes, definitized healthcare change orders, other equitable adjustment healthcare change orders issued after the completion of the negotiations that affect the year just negotiated. If an agreement cannot be reached on the target cost by 30 days before the start of the next option period, the option will be exercised using the prior option period's target cost as specified in Section B as the estimated target cost in Section B. A target-setting formula will be used to determine the target cost. This formula will set the target for the option period retroactively 12 to 18 months after that option period is completed. The contractor will continue to receive payments for underwritten health care costs as addressed in Section G, "Payments", and a portion of fee as addressed in Section H-2, "Partial Payment of Underwriting Fee During Performance".

(c) The retroactive target cost is calculated as follows:

-- actual underwritten CHAMPUS health care costs in the area in the previous option period is multiplied by the national trend factor for underwritten CHAMPUS healthcare costs from the beginning of the previous year up to the end of that year.

(3) Target Underwriting Fee

The term, "target underwriting fee" is equivalent to target fee. The target underwriting fee for all option periods is established at contract award using the contractor's proposed dollar amount for the initial contract award as set forth in Section B. When the parties negotiate the target cost for option period II and/or subsequent periods, the parties will apply the fee percentage proposed at contract award (for the relevant time period) to the negotiated target cost to determine the actual target fee. In the event the parties are unable to negotiate the target cost for option period II and/or subsequent periods, the target underwriting fee will be the dollar amount established at contract award. The target underwriting fee is then only adjusted by negotiated healthcare changes, definitized healthcare change orders, or other equitable adjustments. The parties agree to utilize the same fee percentage proposed for the initial award in these negotiated adjustments.

(4) Minimum and Maximum Fee

The minimum and maximum are as follows:

(a) The minimum fee that may be realized by the contractor will be negative 4 percent of the target cost for each contract year.

(b) The maximum fee that may be realized by the contractor will be 10 percent of the target cost for each contract year.

(5) Fee Determination

The underwriting fee will be determined using the fee adjustment formula as follows:

(a) When underwritten actual costs are less than the target cost, the fee will be the lesser of two amounts: (1) the target fee plus 20% of the difference between the target cost and the actual cost, or (2) the maximum fee amount.

(b) When underwritten actual costs exceed the target, the fee will be the greater of two amounts: (1) the target fee plus 20% of the difference between the target cost and the actual cost (a negative number), or (2) the minimum fee amount (a negative number).

(c) Mathematically, this formula may be expressed as:
Target Fee + .20(Target Cost – Actual Cost)

The final determination of fee will occur approximately 12 to 18 months after the end of the contract year to which it applies. This final determination will be based on underwritten TEDs accepted by TMA through the ninth month after the end of the contract year. However, prior to the fee determination, the Government will determine an interim fee approximately three months after the end of the contract year to which it applies based on the available TED data and the Government's estimate to completion. Partial and final payment of the fee will be conducted in accordance with H-2 and H-3.

(6) Actual Underwritten Healthcare Costs.

Actual underwritten costs for fee determination purposes will be measured from TRICARE Encounter Data (TEDs) accepted by the Government, less unallowable costs determined by audits, and estimated to completion (by the Government). The actual costs will include resource-sharing costs and any other valid, underwritten health-care costs not reported on TEDs, but previously agreed upon by the Government. Healthcare cost details and clarifications include:

(a) Underwritten costs. The target and actual costs will both include all non-TRICARE/Medicare dual-eligible CHAMPUS eligible beneficiaries enrolled with MTF PCMs in addition to all network-enrolled and non-enrolled non-TRICARE/Medicare dual-eligible beneficiaries.

(b) Local Military Treatment Facilities (MTFs) will have control over the purchased-care dollars for all beneficiaries who enroll in TRICARE Prime with an MTF Primary Care Manager (PCM). These enrollees will include Active Duty Service Members (ADSMs) as well as CHAMPUS–eligible beneficiaries. Only those dollars expended for non-

TRICARE/Medicare dual-eligible CHAMPUS beneficiaries will be accumulated as actual healthcare costs to be compared with the target cost for the period.

(c) Enrollment Fees. Enrollment fees collected by the contractor are considered part of the administrative price and are not considered in the determination of the target cost or the actual cost of healthcare under the contract.

(d) Medical Management Costs. The costs of medical-management activities, such as case management, disease management, and utilization management are not considered as healthcare costs.

(e) Capitated Arrangements. Capitation arrangements are prohibited.

H.2. Partial Payment of Underwriting Fee During Performance

In addition to the requirements and procedures specified in this section regarding interim and final health care underwriting fee determination, the Government will make partial payments against the target fee as specified below.

a. During performance of each option period, the Government will pay the contractor, on a monthly pro-rated basis, an amount equal to 50% of the target fee.

b. Interim and final determination of fee for the base period and each subsequent option period will be in accordance with paragraphs H.1. and H.3.

H.3. Interim Fee Determination

a. If the interim fee calculation described in H.1 indicates that a positive fee will be earned upon final determination, the Government will pay the contractor an amount equal to 90% of the target fee for that period. This will be paid in a lump sum to the contractor; less any partial fee payments made for that period. The final balance for fee will be paid 12-18 months after the contract period in accordance with the final fee determination scheme.

b. If the interim fee calculation indicates that a negative fee will be earned upon final determination, no interim fee payments will be made. Final fee determination will be made in accordance with paragraph H.1.

H.4. Resource Sharing

a. Resource sharing is an alternative means of satisfying the purchased-care needs of non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries and is a tool that may be used by the Parties to reduce purchased-care and overall underwritten expenditures. All resource sharing agreements (See the TRICARE Operations Manual, Chapter 16) shall be cost effective to the Government and the contractor.

b. Any allowable resource-sharing expenditure will be reimbursed and will count as actual underwritten healthcare.

c. Although resource sharing is intended primarily to provide care to underwritten CHAMPUS-eligible beneficiaries, when a resource sharing asset provides care to non-underwritten beneficiaries, the costs of providing such care is counted as actual underwritten costs for fee determination, just like resource sharing expenditures for underwritten beneficiaries.

d. There will be no need to account for the number of Military Treatment Facility outpatient visits or admissions enabled by resource sharing for purposes of determining contract payments.

H.5. Allowable Health Care Cost and Payment

a. The purpose of this clause is to define reimbursable healthcare costs and to clarify how healthcare costs apply to FAR clause 52.216-7, “Allowable Cost and Payment”. This clause does not apply to reimbursable costs associated with the disease management administrative services contract line item number. This clause does not substitute any portion of, and does not make changes to FAR 52.216-7.

“Healthcare costs”, as used in this clause, are direct healthcare costs that are underwritten by the contractor.

“Allowable cost”, as used in this clause and FAR 52.216-7 are healthcare costs that pass the TEDS edits. These costs are reimbursed with obligated funds dispersed under this contract. A submission by the contractor to the TEDs system alone does not make it an allowable cost.

Non-underwritten "costs" are costs to the Government, and are not costs to the contractor. Non-underwritten "payments" are draws of funds directly from the Federal Reserve by the contractor. These draws are not considered payments to the contractor, and not considered a reimbursement of allowable healthcare costs from funds obligated on the contract.

b. A submission to TEDs as described in the TRICARE Operations Manual is considered an acceptable invoice or voucher required in accordance with FAR 52.216-7(a)(1).

c. Due to the nature of healthcare costs, the portions of FAR 52.216-7 that relate to materials, direct labor, direct travel, other direct costs, indirect costs, incidental expenses, and pension plan contributions are not applicable. As such, any portions of FAR 52.216-7 that relate to indirect cost rates and billing rates are not applicable.

d. In reference to FAR 52.216-7 (g), "audits", as used in this clause includes audits on statistically valid samples. The audit results will be applied to the entire universe from which the audit sample was drawn to determine total unallowable costs. Overpayments made by the contractor, whether found in an audited sample or audit results applied to the entire universe from which the sample was drawn, are unallowable costs. The Contracting Officer will notify the contractor of intent to disallow costs in accordance with FAR 52.242-1, Notice of Intent to Disallow Costs. Underpayments made by the contractor that are found in an audit are not used to offset overpayment adjustments.

e. In reference to FAR 52.216-7 (h)(2), the Contracting Officer will not approve contractor's expense to secure refunds, rebates, credits, or other amounts (including incentives), as allowable costs for reimbursement under the cost-reimbursable line items, including health care line items.

H.6. Evolving Practices, Devices, Medicines, Treatments and Procedures

a. Medical practices and procedures are expected to continue developing during the period of this contract. Some will increase and some will decrease the cost of medical care. These changes will include practices, devices, medicines, treatments and procedures that previously were excluded from the benefits as unproven. There shall be no change in the Target Cost or Target Fee as a result of changes in the approval status of drugs, devices, medical treatments and medical procedures. The contractor underwrites all costs of all drugs covered under this contract, devices, medical treatments or medical procedures that move from unproven to proven. Changes caused by changes in the statutory definitions of the benefit or new benefits added by statute will be implemented under the Changes clause.

b. TRICARE can only cover costs for medically necessary supplies and services. Regulatory procedures are in place at 32 C.F.R. 199.4(g)(15) that describe the procedure for evaluating the safety and efficacy of unproven drugs, devices, medical treatments, or medical procedures. The contractor shall be responsible for routinely reviewing the hierarchy of reliable evidence, as defined in 32 C.F.R. 199.2, and shall bring to the Government's attention drugs, devices, medical treatments, or medical procedures that they believe have moved from unproven to proven in a written report to the Government in accordance with F-5.

H.7. Integrated Process Teams

The Government may develop major contract and program changes through Integrated Process Teams (IPTs). This provision describes the contractor's participation in this process. The contractor will provide the appropriate personnel (as agreed to by the Contracting Officer and the contractor) to serve on IPTs to develop and/or improve the technical, business, and implementation approach to any and all proposed TRICARE program contract changes within 14 calendar days after notification by the Contracting Officer. The contractor will participate in the entire process with the Government team from concept development through incorporating the change into the contract. This process includes developing budgetary cost estimates, requirement determination, developing rough order of magnitude cost estimates, preparing specifications/statements of work, and establishing a mutually agreeable equitable adjustment to the contract price as a result of incorporating the change (including pricing, negotiations, etc). IPTs will not be formed for all contract changes, but generally will be formed for complex, system-wide issues. The contractor shall participate in all required meetings as determined by the Government team leader, regardless of how they are held (in person, via teleconference, by video-teleconference, or through electronic conferences within the TMA web site). The frequency and scheduling will vary depending on the topic.

H.8. Performance Guarantee

a. The performance guarantee described in this provision is the contractor's guarantee that the contractor's performance will not be less than the performance standards described below. The rights of the Government and remedies described in the Performance Guarantee provision are in accordance with, and in addition to all other rights and remedies of the Government. Specifically, the Government reserves its rights and remedies set forth in the Inspection of Services clause (FAR 52.246-4, 52.246-5) and the Default clause (FAR 52.249-8, 52.249-6).

b. The contractor guarantees that performance will meet or exceed the standards in this provision. For each occurrence the contractor fails to meet each guaranteed standard, the Government will withhold from the contractor the amount listed in the schedule below. Performance guarantee withholds will continue until the guarantee amount for the respective option period is depleted or the contractor's performance improves to meet or exceed the standard. Performance will be measured as specified below. The contractor will be notified and withholds made on a quarterly basis. For the purposes of this provision, the term "performance standard" is defined as the contract standards that are restated in this provision.

c. Performance Guarantee Amounts:

Option Period I $_____

Option Period II $_____

Option Period III $_____

Option Period IV $_____

Option Period V $_____

d. Telephone Service (Busy Signals)

Standard: Not less than 95% of all calls shall be received without the caller encountering a busy signal

A performance guarantee shall be applied as follows:

Based on the contractor's monthly report, the Government will withhold a performance guarantee amount of $0.50 per blocked call in excess of the standard (not less than 95% of all calls shall be received without the caller encountering a busy signal). For example, if 92% of calls are received but 8% are blocked by a busy signal, then a performance guarantee equal to 3% of the calls [3% represents the difference between the actual number of blocked calls and the standard] will be assessed. If 3% equates to 100 calls, the performance guarantee withhold will be $50.00 or 100 times $0.50. The blockage rate shall be determined no less frequently than once per hour.

All calls is defined as any call to any contractor operated TRICARE customer service telephone number. Customer service shall be interpreted in the broadest terms including, but not limited to, telephone calls from beneficiaries, providers, Government representatives, and interested parties about general program information, network providers, enrollment, eligibility, benefits, referrals, preauthorizations/authorizations, claims, complaints, processes and procedures.

e. Telephone Service (Total Hold Time)

Standard: 95% of all calls shall not be on hold for a period of more than 30 seconds during the entire telephone call

A performance guarantee shall be applied as follows:

If performance falls below the standard for each individual call that has a total hold time of more than 30 seconds based on the contractor's monthly report (calls exceeding the 30 second total hold time divided by total calls received during the month), the Government will withhold a performance guarantee amount of $0.50. For example, if only 92% of calls that have a total hold time of 30 seconds are less, the actual number of calls failing the 95% standard will be assessed a performance guarantee. In this example, the difference equals 3%. If 3% of calls equates to 100 calls not meeting the 30 second total hold time standard, the performance guarantee withhold will be $50.00 or, 100 times $0.50.

f. Claims Processing Timeliness (Retained Claims and Adjustment Claims)

Standard: Not less than 95% percent of retained claims and adjustment claims processed shall be completed within 30 calendar days from the date of receipt

A performance guarantee shall be applied as follows:

If the contractor fails to meet the standard, the Government will withhold a performance guarantee amount of $1.00 per retained claim in excess of the 95% standard. For example, if only 91% of retained claims are processed within 30 calendar days, a performance guarantee will be assessed equal to 4% of the claims processed that month. The 4% represents the difference between the actual performance of 91% and the standard of 95%. If 4% equates to 600 claims, the performance guarantee withhold will be $600.00 or 600 times $1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database.

g. Claims Processing Timeliness (Retained Claims)

Standard: 100% of retained claims shall be processed to completion within 60 calendar days

A performance guarantee shall be applied as follows:

If the contractor fails to meet the standard of 100% of retained claims processed to completion within 60 days, the Government will withhold a performance guarantee amount of $1.00 per retained claim not meeting the standard. For example, if actual performance is 99% of retained claims processed to completion within 60 days, the contractor will be assessed a performance guarantee equal to 1% (the difference between the contractor's actual performance and the standard. If 1% equates to 100 claims, the withhold will be $100.00, or 100 times $1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database.

h. Claims Processing Timeliness (Excluded Claims)

Standard: 100% of all claims shall be processed to completion within 120 calendar days.

A performance guarantee shall be applied as follows:

If the contractor fails to meet the standard and falls below the standard of all claims processed to completion within 120 calendar days, the Government will withhold a performance guarantee amount of $1.00 per claim not meeting the standard. For example, if 1% (the difference between the contractor's actual performance and the standard) of all claims are not processed to completion within 120 calendar days from the date of receipt, and that equates to 1,000 claims, the performance guarantee amount will be $1,000.00 or, 1,000 times $1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database. The Government will assess a performance guarantee amount monthly until the claim is processed to completion.

i. Payment Errors

Standard: The absolute value of the payment errors for sampled TEDs (initial submissions, re-submissions, and adjustments/cancellation submissions) shall not exceed 2%.

A performance guarantee shall be applied as follows:

If payment errors exceed the standard, the Government will withhold 10% of the value of payment errors exceeding the 2% standard. The Government will not net errors as a result of overpayments and underpayments. Rather, the Government will withhold a performance guarantee amount equal to 10% of the sum of all payment errors in excess of the standard. This amount will be based on the actual claims audited in the quarterly TMA audits as specified in Section H.

j. TED Edit Accuracy – Validity Edits

Standard: The accuracy rate for TED validity edits shall be not less than:

95 % after six months of performance during the first option period

and

99 % after nine months and thereafter during the entire term of the contract

A performance guarantee shall be applied as follows:

If the contractor fails to meet the standard and falls below either of the two standards of 95 % after six months or 99 % after nine months, a performance guarantee amount of $1.00 for each TED record not meeting the standard will be withheld. For example, if only 90% of all TEDs pass validity edits after six months, then a performance guarantee amount equal to 5% of all TEDs failing the edits during the quarter will be withheld (5% equals the difference between the contractor's actual performance and the standard in this example). If 5% equates to 1,000 TEDs, the performance guarantee amount will be $1,000.00 or 1,000 times $1.00. The number of TEDs failing to meet the standard will be determined monthly based on the TMA TED database.

k. TED Edit Accuracy – Provisional Edits

Standard: The accuracy rate for provisional edits shall not be less than:

90 % after six months of performance during the first option period

and

95 % after nine months and thereafter during the entire term of the contract

A performance guarantee shall be applied as follows:

If the contractor fails to meet the standard and falls below either of the two standards of 90 % after six months or 95 % after nine months, a performance guarantee amount of $1.00 for each TED not meeting the provisional edit standard will be withheld. For example, if only 85% of all TEDs pass provisional edits after six months, a performance guarantee equal to 5%, or the difference between the contractor's actual performance and the standard, will be assessed. If, as in this example, 5% equates to 1,000 TEDs, the performance guarantee will be $1,000.00 or 1,000 times $1.00. The number of TEDs failing to meet the standard will be determined monthly based on the TMA TED database.

l. Contractor Network Adequacy

Standard: Excluding the state of Alaska, not less than 96 percent of contractor referrals of beneficiaries residing within a Prime service area shall be to a MTF or network provider with an appointment available within the access standards.

Based on the contractor's monthly report, a performance guarantee shall be applied as follows for referrals failing the standard:

if less than 96% and more than or equal to 93%	$25.00 per referral*
if less than 93% and more than or equal to 91%	$50.00 per referral*
if less than 91% and more than or equal to 90%	$75.00 per referral*
if less than 90%	$100.00 per referral*

*The withhold will be based on the difference between the contractor's actual performance and the standard.

For purposes of this provision, a referral is the offer of an appropriate appointment within the access standards. If the beneficiary elects not to accept the offered appointment, the contractor has met the standard. In determining the performance guarantee, the applicable amount will be determined based on the offeror's actual performance. For instance, if the contractor's actual performance is 90%, the performance guarantee will equal $75 per referral in excess of 96%. In this example if 5% equals 1,000 referrals failing the standard, the performance guarantee will equal $75,000. It is critical that the contractor recognize that the highest per referral withhold will be applied to all referrals failing the standard. The Government will not stratify the performance guarantee based on the above.

m. Specialty Care Referral/Consultation/Operative Reports

Standard: The contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's initiating provider within 10 working days of the specialty encounter 98% of the time. In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the beneficiary's initiating provider within 24 hours (unless best medical practices dictate less time is required for a preliminary report) by telephone, fax

or other means with a formal written report provided within the standard 98% of the time. All consultation or referral reports, operative reports, and discharge summaries shall be provided to the provider who initiated the referral within 30 calendar days. This standard excludes the state of Alaska.

A performance guarantee shall be applied as follows for visits failing the standard:

Based on the contractor's monthly report, a performance guarantee amount of $100 for each report not provided timely will be withheld. For example, if 97% of reports are provided within the standard, and 100 reports were required, the Government will withhold $300 ($100 x 3 missing/late reports).

H.9. Award Fee

The award fee will be administered quarterly following the completion of each contract quarter in accordance with the award fee plan. The award fee pool is prorated into four equal amounts as shown in Section B and awarded portions disbursed quarterly in accordance with the award fee plan. Unawarded portions of the award fee pool are not available for any subsequent award. The results of the Government administered surveys will be considered in determining the award fee and that any contractor administered survey results are specifically excluded from consideration.

H.10. Processing of Newborn Claims

Processing claims for MTF Prime enrollees with newborns who are not formally enrolled but are covered under the current newborn Prime benefit. The contractor shall first determine if the newborn's claim address indicates residence in the area. If not, refer the claim to the appropriate contractor. The contractor shall process all other newborn claims as follows:

-- If the mother is TRICARE eligible and enrolled within the area, the newborn should have the same reliant status as the mother. If the mother is active duty, skip this step and proceed to checking for siblings as outlined below in step 2.

-- If the mother is not enrolled in the area, identify the enrollment status of the siblings. If there is a TRICARE–eligible sibling enrolled within the area, the newborn should have the same reliant status (e.g., enrolled to the MTF) as the enrolled sibling. In instances of multiple siblings, the hierarchy shall default fall to youngest to oldest sibling.

-- If there is not a TRICARE-eligible mother or sibling enrolled in the area, identify the enrollment status of the father. If the father is a TRICARE-eligible enrolled within the area, the newborn should have the same reliant status as the father.

-- If the first 3 criteria do not lead to financial assignment (i.e., there is no TRICARE eligible mother, sibling or father enrolled within the area), then determine if the newborn resides within a catchment area or non-catchment area. If the newborn resides within a catchment area, assign financial responsibility to the sponsor's PCM (e.g. MTF). If the newborn resides in a non-catchment area, assign responsibility to the contractor.

-- In those cases where a newborn residing in a catchment area does not fall into any of the above criteria, the contractor shall use the residence of the newborn to determine the nearest MTF responsible for that claim. In the instances of overlapping catchment areas, the contractor shall look at the Branch of Service (BOS) and assign financial responsibility to the same BOS.

H.11. Claim Cycletime and Audit Methodology

a. Claim Cycle Time Measurement.

The Government will calculate the claim cycle time based on data submitted on TRICARE Encounter Data (TEDs). The cycle time is calculated as one plus the difference between the Julian date that the claim or adjustment claim was processed to completion and the Julian date of receipt or the Julian date the claim was identified as an adjustment. Only a single cycle time will be calculated per claim. This cycle time will be calculated using all unedited TEDs initial submission vouchers (Voucher Resubmission Number equals zero) which are received by TMA during each quarter and which pass the voucher header edits. TEDs in vouchers which fail the voucher header edits or which are otherwise unprocessable as submitted by the Contractor and TEDs in resubmission vouchers (Voucher Resubmission Number is greater than zero) will be excluded from the claim cycle time calculation.

(1) Claim Audit Sampling and Error Determinations

(a) Sampling Methodology

Sample means will be used as point estimates of payment and occurrence errors. There will be two kinds of payment samples, one for non-denied claims and one for denied claims. The design of non-denied payment and the occurrence samples utilizes a ninety percent (90%) confidence level, while the denied payment sample design uses an eighty percent (80%) confidence level. Precision estimates are 1.0 percent (1%) for the non-denied payment sample, 2.0 percent (2%) for the denied payment sample, and 1.5 percent (1.5%) for the occurrence sample. The non-denied payment sample will be drawn from all records with government payments of $100 to $100,000. In addition, all records with a government payment of $100,000 and over will be audited. The denied payment sample will be drawn from all records with billed amounts of $100 to $100,000. In addition, all records with billed amounts of $100,000 and over will be audited. The non-denied and denied payment samples will be stratified at multiple levels within the $100 to $100,000 range. Samples will be drawn on a quarterly basis from TEDs which pass TMA validity edits. Records to be sampled will be "net" records (i.e. the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in vouchers which fail TRICARE validity edits or which are otherwise unprocessable as submitted by the Contractor will be excluded from the sampling frame.

(b) Required Contractor Documentation.

[1] Upon receipt of the TEDs Internal Control Number (ICN) listing from TMA or designated audit contractor, the Contractor shall retrieve and compile processing documentation for each selected claim. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service. All documentation must be received at TMA or designated audit contractors within 30 calendar days from the date of the TMA or designated audit contractors letter transmitting the ICN listing:

(i) Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, other telephone conversation records.

(ii) Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements; and 4) negotiated rate or fee schedule and such other documents as are required to support the action taken on the claim.

(iii) A copy of the EOB (or EOB facsimile) for each claim selected.

(iv) The contractor shall send via electronic data input on a 3480 cartridge the current family history (15 to 27 months) for each selected claim. This electronic data containing all required data fields must be received by TMA or designated audit contractor within 30 calendar days from the date of the TMA or designated audit contractor letter transmitting the ICN listing.

[2] Payment errors or occurrence errors will be assessed if the Contractor does not provide the above claim-related documents or if the documents provided are not legible. The Contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or designated audit contractors will return original documents upon completion of the audit process.

(c) Additional Data to be Furnished by the Contractor.

[1] Description of data elements by field position in family history file printout. Initial submission to TMA is due by the commencement of claims processing and revisions as they occur.

[2] Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions shall be submitted to TMA by the commencement of claims processing.

[3] Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing. Initial submission to TRICARE is due by the commencement of claims processing and revisions as they occur, but not later than the 5th work day of the month following the change.

[4] Specifications for submission of the provider and pricing files are described in the TEDs System Manual. Initial submission to TMA is due by the commencement of claims processing and updates to the files are to be submitted as specified in the TEDs System Manual.

(d) Payment Error and Process Error Determinations.

[1] There are two categories of payment errors: (1) a payment error which cannot be removed by contractor post payment processing actions and (2) a payment error which can removed by contractor post payment processing actions (see list of audit error codes defining payment error categories). Payment errors which can be removed by contractor post payment actions will also be assessed a process error at audit. If contractor post payment actions substantiate the initial processing decision, the payment error will be removed but the process error will remain. If the initial processing action is not substantiated, both the payment and the process error will remain. Claims containing process errors will not affect payment or occurrence error rates, but will be used as a performance indicator.

[2] Payment errors are the amount of over/under payments on a claim, including but not limited to a payment in the correct amount but sent to the wrong payee, denial of a payable claim, misapplication of the deductible, payment of a noncovered service/supplies, or services/supplies for which a benefit determination cannot be based on the information available at the time of processing. Process errors result from: noncompliance with a required procedure or process, such as development required but not performed, medical emergency not substantiated, medical necessity review not evident and are cited in conjunction with a payment error. Process error determinations are based on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled.

[3] Payment errors which may not be removed by Contractor post payment actions (see audit error categories) are based only on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled. Actions and determinations occurring subsequent to the date the audit sample is pulled or actions and determinations which have not passed the TMA TED Validity edits are not a consideration of the audit regardless of whether resolution of a payment error results. Because adjustment transactions are not allowed on total claim denials, subsequent reprocessing actions to the denied claim which occur prior to the date the audit sample is pulled will be considered during the audit.

[4] The measure of the payment error is the TED record. The audit process (for the payment samples) projects universe value based on the audit results. The samples (non-denied and denied) are separately projected to the universe of claims for each quarter. The results of these projections are then combined into the following categories: total number of claims in the universe, government payment estimation, correct government payment, error amount and the estimated error percent in the universe of claims.

[5] All incorrectly coded financial fields on a TED are considered to be occurrence errors regardless of whether associated errors exist.

(e) Computation of the “Total Amount Billed” for Denied Claims.

[1] For treatment encounters for which no per diem, negotiated rate or DRG-based amount applies for consideration of payment, the “total amount billed” is the actual amount billed on the claims. This applies to treatment encounters involving services from DRG-exempt hospitals and hospital units, those involving DRG-exempt services and those which would otherwise be subject to the DRG-based payment methodology but for which a DRG allowed amount cannot be computed, regardless of whether or not these claim are paid;

[2] For treatment encounters subject to the TRICARE per diem payments, negotiated rate, or the DRG-reimbursement methodology, the “total amount billed” is the correct per diem, negotiated rate, or DRG-based allowable amount including any applicable outlier amounts.

[3] If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, a 100 percent payment error based upon the total amount billed will be assessed. For health care services records which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total amount billed. This condition is considered to be an unsupported TED.

(f) TED Occurrence Error Determination

[1] The TED occurrence error rate is defined as the total number of errors divided by the total number of data fields in the sample times 100.

[2] Occurrence errors determinations are based on only the claim information available and those processing actions taken at the time of adjudication. Actions and determinations occurring subsequent to the processed date of an audited claim, such as obtaining other health insurance documentation, adjusting a claim to correct financial or other data fields,

or developing for required information not obtained prior to processing, are not a consideration of the audit regardless of whether a resolution of the incorrectly coded TED results.

[3] Occurrence errors result from an incorrect entry in any data field of the TED. There are no exceptions. Any error, including errors in financial fields, shall be counted as occurrence errors.

[4] Some TED error conditions are not attributable to any one specific data field but apply to the record as a whole or to certain parts of the record. In addition to erroneous data field coding, the following error conditions involving incorrect or unsupported records will result in occurrence errors being assessed as indicated.

Following are error conditions and the associated number of occurrence errors assessed with each condition; payment error codes that post payment actions do not apply; payment error codes that post-payment actions do apply, and process error codes.

ERROR CONDITION	NUMBER OF ERRORS
Unlike Procedures/Providers Combined (Noninstitutional Record)	7 errors for each additional utilization data set*
Unlike Revenue Codes Combined (Institutional Record)	5 errors for each erroneous revenue code set**
Services Should Be Combined	1 error for each additional revenue code/utilization data set
Missing Noninstitutional Utilization Data Set	7 errors for each missing data set*
Extra Noninstitutional Utilization Data Set	7 errors for each extra data set*
Missing Institutional Revenue Code Set	5 error for each missing revenue code set**
Extra Institutional Revenue Code Set	5 errors for each extra revenue code set**
Incorrect Record Type	5 errors
Claim Not Provided for Audit	1 error plus 1 error for each revenue code utilization data set in the TED
Claim Not Auditable	1 error plus 1 error for each revenue code utilization data set in the TED
Unsupported TED Transaction	1 error plus 1 error for each revenue code utilization data set in the TED

*Not to exceed 21 errors for combination of these error conditions
**Not to exceed 15 errors for combination of these error conditions

The following are payment errors on which post payment actions are either not applicable or would not remove the payment errors assessed.

01K-Authorization *I* PreAuthorization Needed (all — except PPWD* and Adjunctive Dental Authorizations)
03K-Billed Amount Incorrect
04K-Cost-share *I* Deductible Error
07K- Duplicate Services Paid
08K- Eligibility Determination — Patient
09K- Eligibility Determination — Provider
12K- Non-Availability Statement Error
13K-OHI/TPL — Govt. Pay Miscalculated
16K- Payee Wrong- Provider
17K- Participating/Non-Participating Error
18K- Pricing Incorrect
19K-Procedure Code Incorrect
20K-Signature Error
22K- DRG Reimbursement Error
24K-Incorrect Benefit Determination
25K-Claim Not Provided
26K-Claim Not Auditable
27K-Incorrect MCS System

The following are payment errors on which post-payment actions may support original processing. On rebuttal, if documentation is provided that supports the processing actions, the payment errors could be removed but the process errors would remain.

01K-Authorization/Pre-Authorization Needed (PPWD* and adjunctive dental authorizations)
02K-Unsupported Benefit Determination
05K-Development Claim Denied Prematurely
06K-Development Required
10K-Medical Emergency Not Substantiated
11K-Medical Necessity/Review Not Evident
21K-Timely—Filing Error
23K-Contract Jurisdiction Error
99K-Other - This payment error is very general and claims would have to be reviewed on an individual basis with regard to post-payment actions.

*PPWD – Program for Persons with Disabilities

The following are process errors which will be assessed for noncompliance of a required procedure/process. These errors are neither occurrence errors or payment errors and are not used to calculate the occurrence error or payment error rate. A payment error will be assessed along with the process error. Upon rebuttal if the process is followed to conclusion and the actions support the original decision, the payment error will be removed but the process error will remain.

01P - Authorization/Pre-authorization needed (PPWD arid dental authorizations)
02P - Unsupported Benefit Determinations
05P - Development Claim Denied Prematurely
06P - Development Required
10P - Medical Emergency Not Substantiated
11P - Medical Necessity/Review Not Evident
21P - Timely Filing Error
23P - Contract Jurisdiction Error
99P - Other

(2) Error Determination Rebuttals

(a) Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality audit within 45 calendar days of the date of the audit transmittal letters. Rebuttals not postmarked within 45calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when during the audit rebuttal process the contractor submits a claim not previously submitted with the audit and an error is assessed, or when the contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit contractor during the initial rebuttal process must be postmarked within 30 calendar days of the TRICARE or designated quality review contractor rebuttal response letter. Rebuttals to new errors not postmarked within 30 calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 45 to the Julian calendar date of the TMA or designated audit contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit contractor rebuttal response letter.

b. Health Care Cost Audit

TRICARE Encounter Data (TED) voucher payment records are utilized to determine allowable cost. The total allowable amount is calculated on a per record basis, using all fields used to calculate a voucher header total, and for dates of service falling within a specified period. The total government paid amount will be calculated using all edited TEDs initial submission vouchers (Voucher Resubmission Number equals zero) which are received by TMA and which pass the voucher edits. TED voucher records that have not passed all edits on the TED will be excluded from the sample and replaced with a new sample record.

(1) Claim Audit Sampling and Error Determinations.

(a) Sampling Methodology

Sample means will be used as point estimates of payment errors. Payment samples will only include non-denied claims. The design of non-denied payment samples utilizes a ninety percent (90%) confidence level; precision estimates are 1.0 percent (1%) for the non-denied payment sample. The non-denied payment samples will be drawn from all records with Government payments of $100 to $100,000. In addition, all records with a government payment of $100,000 and over will be audited. The non-denied payment samples will be stratified at multiple levels within the $100 to $100,000 range. Samples will be drawn on an annual basis during the seventh month after the end of the option period from TEDs which

pass all TMA edits (the Government reserves its rights to perform specific and/or more frequent audits than annual). Records to be sampled will be "net" records (i.e. the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in vouchers, which fail any TRICARE edit or which are otherwise unprocessable as submitted by the contractor will be excluded from the sampling frame.

(b) Required Contractor Documentation

[1] Upon receipt of the TEDs Internal Control Number (ICN) listing from TMA or designated audit contractor, the Contractor shall retrieve and compile processing documentation for each selected claim. All documentation must be received at TMA or designated audit contractors within thirty (30) calendar days from the date of the TMA or designated audit contractors letter transmitting the ICN listing. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service:

(i) Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, other telephone conversation records.

(ii) Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements; and 4) negotiated rate or fee schedule and such other documents as are required to support the action taken on the claim

(iii) A copy of the EOB (or EOB facsimile) for each claim selected.

(iv) The current family history (15 to 27 months) for each selected claim. The Contractor shall send this via electronic data input on a 3480 cartridge.

[2] If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, a 100 percent payment error based upon the total Government Pay Amount will be assessed. For TEDs which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total Government Pay Amount. This condition is considered to be an unsupported TED. The contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or designated audit contractors will return original documents upon completion of the audit process.

(c) Additional Data to be Furnished by the Contractor

[1] Description of data elements by field position in family history file printout. Initial submission to TMA is due by the commencement of claims processing and revisions as they occur.

[2] Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions shall be submitted to TMA by the commencement of claims processing.

[3] Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing. Initial submission to TRICARE is due by the commencement of claims processing and revisions as they occur, but not later than the fifth (5th) work day of the month following the change.

[4] Specifications for submission of the provider and pricing files are described in the TEDs System Manual. Initial submission to TMA is due by the commencement of claims processing and updates to the files are to be submitted as specified in the TEDs System Manual.

(d) Payment Error Determination for Allowable Cost Audit

[1] The audit error codes (K codes) indicated in above will apply to the cost audit. Payment errors are based on the claim information available and those processing actions taken up to the time the audit sample is pulled. Actions and determinations occurring subsequent to the date the audit sample is pulled are not a consideration of the audit regardless of whether resolution of a payment error results.

[2] Payment errors are the amount of over payments on a claim, including but not limited to misapplication of the deductible, payment of non-covered service/supplies, or payment of services/supplies for which a benefit cannot be

determined based on the information available at the time of processing or a payment in the correct amount but sent to the wrong payee.

[3] The measure of the payment error is the TRICARE Encounter Data record. The audit process (for the payment samples) projects universe value based on the audit results.

(2) Cost Audit Rebuttals

(a) Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality auditor within forty five *(45)* calendar days of the date of the audit transmittal letters. Rebuttals not postmarked within forty five *(45)* calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when, during the audit rebuttal process, the contractor submits a claim not previously submitted with the audit and an error is assessed, or when the contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit contractor during the initial rebuttal process must be postmarked within 30 calendar days of the TRICARE or designated quality review contractor rebuttal response letter. Rebuttals to new errors not postmarked within 30 calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 45 to the Julian calendar date of the TMA or designated audit contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit contractor rebuttal response letter.

(b) The rebuttal for the healthcare cost audit shall be certified by a responsible official of the contractor as to accuracy and completeness. The rebuttal submission and the rebuttal process used by the contractor shall be subject to review by the Government. The corporation and/or certifying individual may be subject to criminal prosecution for any false certifications made.

H.12. Assumption of Performance in a Second TRICARE Contract Area

TRICARE is a statutory entitlement program under which there can be no lapse in program execution or interruption of services. It is the Government's duty to take all reasonable steps to ensure the ready availability of alternative contract sources to facilitate stability in administration of the statutory entitlement program, help avoid unnecessary disruption in healthcare provider and patient relationships, and insure continuation of critical health services. Recognizing the potential that circumstances may arise under which the Government may require an alternative contractor to assume, on an interim basis, contract performance in one of the three TRICARE contract areas, the Government will consider other options, including substituting contract performance by one or both of the other contractors pending competitive acquisition of a successor. The Government agrees to negotiate in good faith fair and reasonable compensation for the additional work to be performed. The contractor retains all rights to equitable adjustments under the Changes clause in this matter.